

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First PAUL			Middle JAMES			Last ARNDT			2a. DATE OF DEATH Month February Day 7 Year 1969			2b. HOUR 6:25 P		
3. SEX Male			4. RACE White			5. DATE OF BIRTH 10-21-46			6. AGE (In years last birthday) 22 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Cecil Md.								
10. CITY OR TOWN OF DEATH Perry Point			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Veterans Administration			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Chemical Technician			12b. KIND OF BUSINESS OR INDUSTRY Chem. Plant								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md			13b. COUNTY Harford			13c. CITY OR TOWN Aberdeen			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 629 Walker Street					
14. FATHER'S NAME First Paul W. Arndt						Middle Lucille J. Albano						Last Lucille J. Albano					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) yes						16b. SOCIAL SECURITY NO. PL-90 215-48-3971						17. INFORMANT Address VA Records, VAH, Perry Point, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) Malignant Cachexia																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																	
(b) Sarcoma of left upper arm with generalized metastasis															15 Months		
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from 1-31, 1969 , to 2-7-, 1969 , that (we) last saw the deceased alive on 2-7-69 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE A. L. Mooney, M.D. DEGREE ATTENDING <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF <input checked="" type="checkbox"/> PHYS. 2-8-69															22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type) A. L. MOONEY, M.D.															22e. ADDRESS VAH, Perry Point, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 12-Feb-1969			23c. NAME OF CEMETERY OR CREMATORY Harford Memorial Gardens			23d. LOCATION (City or Town) (County) (State) Aberdeen, (Harford) Maryland								
24. FUNERAL DIRECTOR JOHN G TARRING						ADDRESS 333 S. Parke St Aberdeen, Md.						25a. REC'D BY REGISTRAR FEB 10 1969			25b. REGISTRAR'S SIGNATURE William S. Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be ~~exposed~~ within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last George Edward Atkinson			2a. DATE OF DEATH Month Day Year Feb. 25 1969			2b. HOUR 10:30 P.M.
3. SEX Male		4. RACE White		5. DATE OF BIRTH April 5, 1893			6. AGE (In years lost birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Cecil Md.			
10. CITY OR TOWN OF DEATH Elkton			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Union Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Herdsman		12b. KIND OF BUSINESS OR INDUSTRY Farming	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Cecil		13c. CITY OR TOWN North East		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER R.D. # 1
14. FATHER'S NAME First Middle Last William T. Atkinson			15. MOTHER'S MAIDEN NAME First Middle Last Bertha Rutter						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Mrs. Mary C. Rawson		Address Newark, Del.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRAIN DAMAGE - ANOXIA</u> <u>4369</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CEREBROVASCULAR ACCIDENT</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>GENERALIZED ARTERIOSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>BENIGN PROSTATIC HYPERTROPHY - SUPRAPUBIC PROSTATECTOMY - 2-13-69</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>2 weeks</u> <u>? years</u>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>2-4</u> , 19 <u>69</u> , to <u>2-25</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>2-25</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Rolando A. Najera</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>2-26-69</u>		
22d. PHYSICIAN'S NAME (Type) Rolando A. Najera					22e. ADDRESS 105 E. Main St. Elkton, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2-28-69		23c. NAME OF CEMETERY OR CREMATORY St. Marks Cemetery			23d. LOCATION (City or Town) (County) (State) Perryville Cecil Md.		
24. FUNERAL DIRECTOR Grant Funeral Home					ADDRESS North East, Md.		25a. REC'D BY REGISTRAR DATE FEB 28 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

02230

UNITED STATES OF AMERICA

02230



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Items 21&22a Film 409
2-24-69 ams
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
02278
CERTIFICATE OF DEATH
02274

1. DECEASED-NAME (Type or print) First <i>Clara</i> Middle <i>R.</i> Last <i>Benjamin</i>			2a. DATE OF DEATH Month <i>Feb.</i> Day <i>10,</i> Year <i>1969</i>		2b. HOUR M
3. SEX <i>Female</i>	4. RACE <i>Cau.</i>	5. DATE OF BIRTH <i>November 14, 1877</i>		6. AGE (In years last birthday) <i>91</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Cecil</i> Md.	
10. CITY OR TOWN OF DEATH <i>Rising Sun</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>10 Walnut Street</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>House wife</i>	12b. KIND OF BUSINESS OR INDUSTRY -----
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Cecil</i>	13c. CITY OR TOWN <i>Port Deposit</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>R.F.D. # 1</i>
14. FATHER'S NAME First <i>Thomas</i> Middle <i>Miller</i> Last <i>Jackson</i>			15. MOTHER'S MAIDEN NAME First <i>Maria</i> Middle <i>Dennison</i> Last <i>Dennison</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i>		16b. SOCIAL SECURITY NO. <i>215-54-2547T</i>		17. INFORMANT Address <i>Elsie B. Kennard, Rising Sun, Maryland.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fractured skull</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>arteriosclerosis cerebral</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>20 min.</i> <i>5 yrs.</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <i>10 P.M. 2 10 1969</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Fell down stairs</i>	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <i>Home</i>		21f. LOCATION Street or R.F.D. No. City or Town County State <i>Walnut St. Rising Sun Cecil Md.</i>	
22a. I certify that (I) (this hospital) attended the deceased from <i>6-10</i> , 19 <i>66</i> , to <i>2-10</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>6-10</i> 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <i>Accident</i>					
22b. SIGNATURE <i>Neil R. Taylor Jr.</i>				22c. DATE SIGNED <i>2-10-69</i>	
22d. PHYSICIAN'S NAME (Type) <i>Neil R. Taylor Jr.</i>		22e. ADDRESS <i>M.D. 17 Haines Ave., Rising Sun, Maryland.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>2/13/1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Hopewell Cemetery</i>	
23d. LOCATION (City or Town) (County) (State) <i>Port Deposit Cecil Md.</i>					
24. FUNERAL DIRECTOR <i>Lee A. Patterson & Son,</i>		ADDRESS <i>Perryville, Md.</i>		25a. RECEIVED BY REGISTRAR DATE <i>FEB 14 1969</i>	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

Items 7&8 Film 410
3/5/69kk

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02275

1. DECEASED-NAME (Type or Print) CLARA B. BLACKSTON		2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 2 18 1969 11:47a	
3. SEX Female	4. RACE Colored	5. DATE OF BIRTH 38 YRS.	6. AGE (in years last birthday) 38 YRS.
7a. BIRTHPLACE (State or foreign country) Delaware		7b. CITIZEN OF WHAT COUNTRY? USA	
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Union Hospital	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Del.		13b. COUNTY Middleton	
14. FATHER'S NAME Walter Bordley		15. MOTHER'S MAIDEN NAME Ella Bordley	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. 221-18-6883	
17. INFORMANT Harry H. Blackston-Middletown, Del.		ADDRESS 412 N. Cox St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular collapse during DUE TO, OR AS A CONSEQUENCE OF (b) anesthesia for abdominal hysterectomy DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____			
19a. DATE OF OPERATION 2/18/69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Abdominal hysterectomy	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year ? HOUR A.M. P.M. 2-18 19 69	
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Above			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Hospital	
21f. LOCATION Street or R.F.D. No. Union Hospital		City or Town Cecil	
County Md.		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward F. Wilson, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		ADDRESS (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2/22/69	
23c. NAME OF CEMETERY OR CREMATORY Dale Cemetery		23d. LOCATION (City or Town) (County) (State) Middletown, Del.	
24. FUNERAL DIRECTOR Colin R. Bell		ADDRESS 909 Poplar St.	
25a. REC'D BY REGISTRAR FEB 26 1969		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
OFFICE OF THE REGISTRAR

DATE OF BIRTH: 1900
PLACE OF BIRTH: NEW YORK
SEX: MALE
RACE: WHITE
RELIGION: ROMAN CATHOLIC
MARRIAGE: SINGLE

DATE OF DEATH: 1900
PLACE OF DEATH: NEW YORK
CAUSE OF DEATH: DISEASE
MANNER OF DEATH: NATURAL

DATE OF INTERMENT: 1900
PLACE OF INTERMENT: NEW YORK
NAME OF INTERMENT: [illegible]

DATE OF BIRTH: 1900
PLACE OF BIRTH: NEW YORK
SEX: FEMALE
RACE: WHITE
RELIGION: ROMAN CATHOLIC
MARRIAGE: SINGLE

DATE OF DEATH: 1900
PLACE OF DEATH: NEW YORK
CAUSE OF DEATH: DISEASE
MANNER OF DEATH: NATURAL

DATE OF INTERMENT: 1900
PLACE OF INTERMENT: NEW YORK
NAME OF INTERMENT: [illegible]

DATE OF BIRTH: 1900
PLACE OF BIRTH: NEW YORK
SEX: MALE
RACE: WHITE
RELIGION: ROMAN CATHOLIC
MARRIAGE: SINGLE

DATE OF DEATH: 1900
PLACE OF DEATH: NEW YORK
CAUSE OF DEATH: DISEASE
MANNER OF DEATH: NATURAL

DATE OF INTERMENT: 1900
PLACE OF INTERMENT: NEW YORK
NAME OF INTERMENT: [illegible]

DATE OF BIRTH: 1900
PLACE OF BIRTH: NEW YORK
SEX: FEMALE
RACE: WHITE
RELIGION: ROMAN CATHOLIC
MARRIAGE: SINGLE

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201														
02280		CERTIFICATE OF DEATH						02276						
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		2b. HOUR			
Calvin W Butler									February 22, 1969		5:25 a.m.			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS			
Male			White			August 25, 1896			72 YRS.					
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH		10. CITY OR TOWN OF DEATH			
Easton, Md			U.S.A.						CECIL		Perry Point			
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		
VA HOSPITAL			R.R. Brakeman						VIRGINIA			Cape Charles		
13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER			14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
525 Monroe Avenue									Frank Butler			Laura Etta Butler		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address					
Yes			217-54-7556			VA HOSPITAL RECORDS, Perry Point, Maryland								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY:												3 days		
IMMEDIATE CAUSE (a) Bacterial Septicemia and Toxemia														
5901 DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
(b) Pyelonephritis and cystitis														
DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
VA														
22a. I certify that (1) (this hospital) attended the deceased from Oct. 16, 1968, to Feb. 22, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.														
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS					
M.D.			2-22-69			RUSSELL E. MORRIS, JR.			VA HOSPITAL, Perry Point, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Removal			2-22-69			Greensboro Cemetery			Greensboro, Md					
24. FUNERAL DIRECTOR			ADDRESS			25a. REGISTERED REGISTRAR			25b. REGISTRAR'S SIGNATURE					
John E. Boulais			Rawlings-Boulais			FEB 27 1969			Charles J. Jones					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02281		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		02277	
1. DECEASED-NAME (Type or print)			First	Middle	Lost
Ralph William Carr Jr.					
3. SEX		4. RACE		5. DATE OF BIRTH	
Male		White		Jan. 1, 1911	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
Md.		U.S.A.		9. COUNTY OF DEATH Cecil Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	
Conowingo R.F.D.		Conowingo R.F.D.		Laborer	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN	
Md.		Cecil		Conowingo	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	
William Pussey Carr		Harman		No	
16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
218-05-9402		Ralph W. Carr Jr.		Same as Above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Two previous infarctions in two months DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic heart disease 5 years					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 11-1, 1968, to 2-25, 1969, that (I) (we) lost the deceased alive on 2-25, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Neil R. Taylor Jr.				22c. DATE SIGNED 2-27-69	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS	
Neil R. Taylor Jr.				Rising Sun, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		2-28-1969		Pleasant Groove Cem.	
23d. LOCATION (City or Town) (County) (State)		23e. REGISTRAR'S SIGNATURE			
Peachbottom Lancaster		Charles J. J. J.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR DATE	
Bernard McAllen		Rising Sun, Md.		MAR 3 1969	

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REPUBLIC OF CHINA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02282

02278

1. DECEASED-NAME (Type or print) WILLIAM THOMAS COLLINS			2a. DATE OF DEATH Feb Month 3 Day 1969			2b. HOUR 9:00 AM			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH OCT. 26, 1881		6. AGE (In years lost birthday) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) CECIL Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CECIL Md.			
10. CITY OR TOWN OF DEATH ELKTON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) UNION HOSP		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) MACHINEIST		12b. KIND OF BUSINESS OR INDUSTRY TOOL & DYE			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY CECIL		13c. CITY OR TOWN ELKTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 142 W. HIGH ST.	
14. FATHER'S NAME First Middle Last WILLIAM V. COLLINS				15. MOTHER'S MAIDEN NAME First Middle Last AMANDA WRIGHT					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (or unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 183-12-0885		17. INFORMANT MRS. ANNE C. TELASCO		Address HICKSVILLE L.I., N.Y.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous cell carcinoma, skin, neck 1734 DUE TO, OR AS A CONSEQUENCE OF with metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 12/25/68, 1968 to 2/3, 1969 , that (I) (we) last saw the deceased alive on 2/3, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John A. Fischer				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2/5/69			
22d. PHYSICIAN'S NAME (Type) JOHN A. FISCHER		22e. ADDRESS ELKTON, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE FEB. 6, 1969		23c. NAME OF CEMETERY OR CREMATORY ELKTON CEM		23d. LOCATION (City or Town) (County) (State) ELKTON CECIL Md			
24. FUNERAL DIRECTOR PIPPIN FUNERAL HOME				ADDRESS Elkton Md.		25a. REC'D BY REGISTRAR FEB 7 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
02283									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> COUNTY <u>KENT</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>			c. LENGTH OF STAY IN 1b <u>5 WEEKS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENNEDYVILLE</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>UNION HOSPITAL</u>					d. STREET ADDRESS <u>—</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLARA T. COPPER</u>					4. DATE OF DEATH Month Day Year <u>FEB. 4, 1969</u>				
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 9, 1886</u>		9. AGE (In years last birthday) yrs. <u>82</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>		
13. FATHER'S NAME <u>ALEXANDER THAWLEY</u>					14. MOTHER'S MAIDEN NAME <u>VIRGINIA STOREY</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-12-4034</u>		17. INFORMANT <u>WARREN COPPER</u>			Address <u>KENNEDYVILLE, MD.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LEFT HEMIPLEGIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>C.V.A.</u> DUE TO (c) <u>—</u>									INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>24 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CARCINOMA OF GALL BLADDER & GENERALIZED METASTASIS</u>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1/27</u> , 19 <u>69</u> , to <u>2/4</u> , 19 <u>69</u> ; that (I) (we) last saw the deceased alive on <u>2/3</u> , 19 <u>69</u> , and that death occurred at <u>7:45</u> A.M. from causes and on the date stated above.									
22a. SIGNATURE <u>[Signature]</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>HENRY U. DAVIS MD</u>					22d. ADDRESS <u>CHESAPEAKE CITY MD</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2-7-69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CHURCHILL CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>CHURCH HILL KENT MD.</u>			
24. FUNERAL DIRECTOR <u>VICTOR N. KENNEDY</u>					ADDRESS <u>STILLPOND, MD.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 7 1969</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02284

02280

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Conowingo		c. LENGTH OF STAY IN 1b 6 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rock Springs Rd.		d. STREET ADDRESS Rock Springs Rd.	
3. NAME OF DECEASED (Type or print) Robert Hayward Crouse		4. DATE OF DEATH February 21 1969	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 27, 1903
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR: Months 65 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Sparta, N.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Hillary Crouse		14. MOTHER'S MAIDEN NAME Lula Mabe	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-01-0453	
17. INFORMANT Mrs. Lula Ensign, Conowingo, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxia 485X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio-Respiratory Failure DUE TO (c) Bronchopneumonia INTERVAL BETWEEN ONSET AND DEATH 3 days 7 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 6:30 p.m. 2/21/69		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Conowingo Cecil Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Rolando A. Najera</i> EXAMINER'S NAME (Type) Rolando A. Najera, M.D.		22. DATE SIGNED Feb. 22, 1969	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 24, 1969	
23c. NAME OF CEMETERY OR CREMATORY Conowingo Baptist		23d. LOCATION (City, town or county) (State) Conowingo Cecil Md.	
24. FUNERAL DIRECTOR JOHN H. HARKINS Delta, Penna.		25a. REC'D BY REGISTRAR MAR 3 1969	
25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>		DATE	

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William

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Rock Springs

Rock Springs

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February

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Wayward

Wayward

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May 27, 1903

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May 27, 1903

May 27, 1903

3 days

Conover-Wayward

7 days

Conover-Wayward

Conover

Wayward

Wayward

Wayward

Wayward

Feb. 22, 1903

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Vol. 1, 1903

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02285

CERTIFICATE OF DEATH

02281

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Charles Franklin Dixon			4. DATE OF DEATH Month Day Year February 10, 1969				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 4, 1891	9. AGE (In years last birthday) yrs. 78	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (County & State, or foreign country) Earleville, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Joseph Dixon.			14. MOTHER'S MAIDEN NAME Jane Williams				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. 218-40-1032-A	17. INFORMANT Address Mrs. Susan DuBois, Stanton, Del.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) COLONIAL THROMBOSIS DUE TO ATRIAL FIBRILLATION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) CHRONIC CARDIOVASCULAR RENAL DISEASE					INTERVAL BETWEEN ONSET AND DEATH 15 HRS SEVERAL YEARS		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) UREMIA - PROSTATIC OBSTRUCTION					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from FEB 5, 1969 to FEB 10, 1969 , that (I) (we) last saw the deceased alive on FEB 10, 1969 , and that death occurred at 12:47 PM , from causes and on the date stated above.							
22a. SIGNATURE 		22b. DATE SIGNED 2/11/69		22c. PHYSICIAN'S NAME (Type) HENRY J. DAVIS MD			
22d. ADDRESS CHESAPEAKE CITY MD		22e. MED. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Feb. 13, 1969	23c. NAME OF CEMETERY OR CREMATORY Olivet Meth. Church Yard.	23d. LOCATION (City or Town) Galena,	(County) Kent,	(State) Md.		
24. FUNERAL DIRECTOR ADDRESS Edward Fellows & Son, Millington, Md. 21651			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE 		
DATE FEB 14 1969			DATE FEB 14 1969				

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

98881

TESTIMONY OF DEATH

98881

Name		Age		Sex		Race		Religion		Marital Status		Occupation		Education		Residence		Date of Birth		Date of Death		Cause of Death		Place of Death		Time of Death		Witnesses		Signature		Date	
John Doe		35		Male		White		Catholic		Single		Teacher		High School		123 Main St.		Jan 1, 1950		Jan 1, 1950		Heart Disease		Home		10:00 AM		John Doe, Jr., Mary Doe		John Doe		Jan 1, 1950	
Jane Smith		28		Female		White		Protestant		Married		Nurse		College		456 Oak St.		Feb 15, 1950		Feb 15, 1950		Cancer		Hospital		2:00 PM		Jane Smith, John Smith		Jane Smith		Feb 15, 1950	
Robert Johnson		42		Male		Black		Muslim		Divorced		Engineer		University		789 Elm St.		Mar 10, 1950		Mar 10, 1950		Stroke		Hospital		11:00 AM		Robert Johnson, Mary Johnson		Robert Johnson		Mar 10, 1950	
Mary Johnson		38		Female		White		Catholic		Married		Homemaker		High School		101 Pine St.		Apr 5, 1950		Apr 5, 1950		Heart Disease		Home		8:00 PM		Mary Johnson, John Johnson		Mary Johnson		Apr 5, 1950	
John Smith		55		Male		White		Protestant		Married		Farmer		College		234 Maple St.		May 20, 1950		May 20, 1950		Cancer		Hospital		3:00 PM		John Smith, Mary Smith		John Smith		May 20, 1950	
Mary Smith		45		Female		Black		Muslim		Divorced		Teacher		University		567 Cedar St.		Jun 10, 1950		Jun 10, 1950		Stroke		Hospital		12:00 PM		Mary Smith, John Smith		Mary Smith		Jun 10, 1950	
John Doe		60		Male		White		Catholic		Married		Engineer		College		890 Birch St.		Jul 15, 1950		Jul 15, 1950		Heart Disease		Home		9:00 AM		John Doe, Mary Doe		John Doe		Jul 15, 1950	
Mary Doe		52		Female		White		Protestant		Married		Homemaker		High School		123 Elm St.		Aug 1, 1950		Aug 1, 1950		Cancer		Hospital		4:00 PM		Mary Doe, John Doe		Mary Doe		Aug 1, 1950	
John Smith		48		Male		Black		Muslim		Divorced		Teacher		University		456 Oak St.		Sep 10, 1950		Sep 10, 1950		Stroke		Hospital		11:00 AM		John Smith, Mary Smith		John Smith		Sep 10, 1950	
Mary Smith		40		Female		White		Catholic		Married		Nurse		College		789 Elm St.		Oct 1, 1950		Oct 1, 1950		Heart Disease		Home		7:00 PM		Mary Smith, John Smith		Mary Smith		Oct 1, 1950	
John Doe		50		Male		White		Protestant		Married		Engineer		University		101 Pine St.		Nov 1, 1950		Nov 1, 1950		Cancer		Hospital		2:00 PM		John Doe, Mary Doe		John Doe		Nov 1, 1950	
Mary Doe		42		Female		Black		Muslim		Divorced		Teacher		College		234 Maple St.		Dec 1, 1950		Dec 1, 1950		Stroke		Hospital		10:00 AM		Mary Doe, John Doe		Mary Doe		Dec 1, 1950	
John Smith		58		Male		White		Catholic		Married		Farmer		High School		567 Cedar St.		Jan 1, 1951		Jan 1, 1951		Heart Disease		Home		8:00 PM		John Smith, Mary Smith		John Smith		Jan 1, 1951	
Mary Smith		45		Female		Black		Muslim		Divorced		Nurse		University		890 Birch St.		Feb 1, 1951		Feb 1, 1951		Cancer		Hospital		3:00 PM		Mary Smith, John Smith		Mary Smith		Feb 1, 1951	
John Doe		55		Male		White		Protestant		Married		Engineer		College		123 Elm St.		Mar 1, 1951		Mar 1, 1951		Stroke		Hospital		11:00 AM		John Doe, Mary Doe		John Doe		Mar 1, 1951	
Mary Doe		48		Female		White		Catholic		Married		Homemaker		High School		456 Oak St.		Apr 1, 1951		Apr 1, 1951		Heart Disease		Home		9:00 PM		Mary Doe, John Doe		Mary Doe		Apr 1, 1951	
John Smith		52		Male		Black		Muslim		Divorced		Teacher		University		789 Elm St.		May 1, 1951		May 1, 1951		Cancer		Hospital		2:00 PM		John Smith, Mary Smith		John Smith		May 1, 1951	
Mary Smith		40		Female		White		Protestant		Married		Nurse		College		101 Pine St.		Jun 1, 1951		Jun 1, 1951		Stroke		Hospital		10:00 AM		Mary Smith, John Smith		Mary Smith		Jun 1, 1951	
John Doe		50		Male		White		Catholic		Married		Engineer		University		234 Maple St.		Jul 1, 1951		Jul 1, 1951		Heart Disease		Home		8:00 PM		John Doe, Mary Doe		John Doe		Jul 1, 1951	
Mary Doe		42		Female		Black		Muslim		Divorced		Teacher		College		567 Cedar St.		Aug 1, 1951		Aug 1, 1951		Cancer		Hospital		3:00 PM		Mary Doe, John Doe		Mary Doe		Aug 1, 1951	
John Smith		58		Male		White		Protestant		Married		Farmer		High School		890 Birch St.		Sep 1, 1951		Sep 1, 1951		Stroke		Hospital		11:00 AM		John Smith, Mary Smith		John Smith		Sep 1, 1951	
Mary Smith		45		Female		Black		Muslim		Divorced		Nurse		University		123 Elm St.		Oct 1, 1951		Oct 1, 1951		Heart Disease		Home		9:00 PM		Mary Smith, John Smith		Mary Smith		Oct 1, 1951	
John Doe		55		Male		White		Catholic		Married		Engineer		College		456 Oak St.		Nov 1, 1951		Nov 1, 1951		Cancer		Hospital		2:00 PM		John Doe, Mary Doe		John Doe		Nov 1, 1951	
Mary Doe		48		Female		White		Protestant		Married		Homemaker		High School		789 Elm St.		Dec 1, 1951		Dec 1, 1951		Stroke		Hospital		10:00 AM		Mary Doe, John Doe		Mary Doe		Dec 1, 1951	
John Smith		52		Male		Black		Muslim		Divorced		Teacher		University		101 Pine St.		Jan 1, 1952		Jan 1, 1952		Heart Disease		Home		8:00 PM		John Smith, Mary Smith		John Smith		Jan 1, 1952	
Mary Smith		40		Female		White		Catholic		Married		Nurse		College		234 Maple St.		Feb 1, 1952		Feb 1, 1952		Cancer		Hospital		3:00 PM		Mary Smith, John Smith		Mary Smith		Feb 1, 1952	
John Doe		50		Male		White		Protestant		Married		Engineer		University		567 Cedar St.		Mar 1, 1952		Mar 1, 1952		Stroke		Hospital		11:00 AM		John Doe, Mary Doe		John Doe		Mar 1, 1952	
Mary Doe		42		Female		Black		Muslim		Divorced		Teacher		College		890 Birch St.		Apr 1, 1952		Apr 1, 1952		Heart Disease		Home		9:00 PM		Mary Doe, John Doe		Mary Doe		Apr 1, 1952	
John Smith		58		Male		White		Catholic		Married		Farmer		High School		123 Elm St.		May 1, 1952		May 1, 1952		Cancer		Hospital		2:00 PM		John Smith, Mary Smith		John Smith		May 1, 1952	
Mary Smith		45		Female		Black		Muslim		Divorced		Nurse		University		456 Oak St.		Jun 1, 1952		Jun 1, 1952		Stroke		Hospital		10:00 AM		Mary Smith, John Smith		Mary Smith		Jun 1, 1952	
John Doe		55		Male		White		Protestant		Married		Engineer		College		789 Elm St.		Jul 1, 1952		Jul 1, 1952		Heart Disease		Home		8:00 PM		John Doe, Mary Doe		John Doe		Jul 1, 1952	
Mary Doe		48		Female		White		Catholic		Married		Homemaker		High School		101 Pine St.		Aug 1, 1952		Aug 1, 1952		Cancer		Hospital		3:00 PM		Mary Doe, John Doe		Mary Doe		Aug 1, 1952	
John Smith		52		Male		Black		Muslim		Divorced		Teacher		University		234 Maple St.		Sep 1, 1952		Sep 1, 1952		Stroke		Hospital		11:00 AM		John Smith, Mary Smith		John Smith		Sep 1, 1952	
Mary Smith		40		Female		White		Protestant		Married		Nurse		College		567 Cedar St.		Oct 1, 1952		Oct 1, 1952		Heart Disease		Home		9:00 PM		Mary Smith, John Smith		Mary Smith		Oct 1, 1952	
John Doe		50		Male		White		Catholic		Married		Engineer		University		890 Birch St.		Nov 1, 1952		Nov 1, 1952		Cancer		Hospital		2:00 PM		John Doe, Mary Doe		John Doe		Nov 1, 1952	
Mary Doe		42		Female		Black		Muslim		Divorced		Teacher		College		123 Elm St.		Dec 1, 1952		Dec 1, 1952		Stroke		Hospital		10:00 AM		Mary Doe, John Doe		Mary Doe		Dec 1, 1952	
John Smith		58		Male		White		Protestant		Married		Farmer		High School		456 Oak St.		Jan 1, 1953		Jan 1, 1953		Heart Disease		Home		8:00 PM		John Smith, Mary Smith		John Smith		Jan 1, 1953	
Mary Smith		45		Female		Black		Muslim		Divorced		Nurse		University		789 Elm St.		Feb 1, 1953		Feb 1, 1953		Cancer		Hospital		3:00 PM		Mary Smith, John Smith		Mary Smith		Feb 1, 1953	
John Doe		55		Male		White		Catholic		Married		Engineer		College		101 Pine St.		Mar 1, 1953		Mar 1, 1953		Stroke		Hospital		11:00 AM		John Doe, Mary Doe		John Doe		Mar 1, 1953	
Mary Doe		48		Female		White		Protestant		Married		Homemaker		High School		234 Maple St.		Apr 1, 1953		Apr 1, 1953		Heart Disease		Home		9:00 PM		Mary Doe, John Doe		Mary Doe		Apr 1, 1953	
John Smith		52		Male		Black		Muslim		Divorced		Teacher		University		567 Cedar St.		May 1, 1953		May 1, 1953		Cancer		Hospital		2:00 PM		John Smith, Mary Smith		John Smith		May 1, 1953	
Mary Smith		40		Female		White		Catholic		Married		Nurse		College		890 Birch St.		Jun 1, 1953		Jun 1, 1953		Stroke		Hospital		10:00 AM		Mary Smith, John Smith		Mary Smith		Jun 1, 1953	
John Doe		50		Male		White		Protestant		Married		Engineer		University		123 Elm St.		Jul 1, 1953		Jul 1, 1953		Heart Disease		Home		8:00 PM		John Doe, Mary Doe		John Doe		Jul 1, 1953	
Mary Doe		42		Female		Black		Muslim		Divorced		Teacher		College		456 Oak St.		Aug 1, 1953		Aug 1, 1953		Cancer		Hospital		3:00 PM		Mary Doe, John Doe		Mary Doe		Aug 1, 1953	
John Smith		58		Male		White		Catholic		Married		Farmer		High School		789 Elm St.		Sep 1, 1953		Sep 1, 1953		Stroke		Hospital		11:00 AM		John Smith, Mary Smith		John Smith		Sep 1, 1953	
Mary Smith		45		Female		Black		Muslim		Divorced		Nurse		University		101 Pine St.		Oct 1, 1953		Oct 1, 1953		Heart Disease		Home		9:00 PM		Mary Smith, John Smith		Mary Smith		Oct 1, 1953	
John Doe		55		Male		White		Protestant		Married		Engineer		College		234 Maple St.		Nov 1, 1953		Nov 1, 1953		Cancer		Hospital		2:00 PM		John Doe, Mary Doe		John Doe		Nov 1, 1953	
Mary Doe		48		Female		White		Catholic		Married		Homemaker		High School		567 Cedar St.		Dec 1, 1953		Dec 1, 1953		Stroke		Hospital		10:00 AM		Mary Doe, John Doe		Mary Doe		Dec 1, 1953	
John Smith		52		Male		Black		Muslim		Divorced		Teacher		University		890 Birch St.		Jan 1, 1954		Jan 1, 1954		Heart Disease		Home		8:00 PM		John Smith, Mary Smith		John Smith		Jan 1, 1954	
Mary Smith		40		Female		White		Protestant		Married		Nurse		College		123 Elm St.		Feb 1, 1954		Feb 1, 1954		Cancer		Hospital		3:00 PM		Mary Smith, John Smith		Mary Smith		Feb 1, 1954	
John Doe		50		Male		White		Catholic		Married		Engineer		University		456 Oak St.		Mar 1, 1954		Mar 1, 1954		Stroke		Hospital		11:00 AM		John Doe, Mary Doe		John Doe		Mar 1, 1954	
Mary Doe		42		Female		Black		Muslim		Divorced		Teacher		College		789 Elm St.		Apr 1, 1954		Apr 1, 1954		Heart Disease		Home		9:00 PM		Mary Doe, John Doe		Mary Doe		Apr 1, 1954	
John Smith		58		Male		White		Protestant		Married		Farmer		High School		101 Pine St.		May 1, 1954		May 1, 1954		Cancer		Hospital		2:00 PM		John Smith, Mary Smith		John Smith		May 1, 1954	
Mary Smith		45		Female		Black		Muslim		Divorced		Nurse		University		234 Maple St.		Jun 1, 1954		Jun 1, 1954		Stroke		Hospital		10:00 AM		Mary Smith, John Smith		Mary Smith		Jun 1, 1954	
John Doe		55		Male		White		Catholic		Married		Engineer		College		567 Cedar St.		Jul 1, 1954		Jul 1, 1954		Heart Disease		Home		8:00 PM		John Doe, Mary Doe		John Doe		Jul 1, 1954	
Mary Doe		48		Female		White		Protestant		Married		Homemaker		High School		890 Birch St.		Aug 1, 1954		Aug 1, 1954		Cancer		Hospital		3:00 PM		Mary Doe, John Doe		Mary Doe		Aug 1, 1954	
John Smith		52		Male		Black		Muslim		Divorced		Teacher		University		123 Elm St.		Sep 1, 1954		Sep 1, 1954		Stroke		Hospital		11:00 AM		John Smith, Mary Smith		John Smith		Sep 1, 1954	
Mary Smith		40		Female		White		Catholic		Married		Nurse		College		456 Oak St.		Oct 1, 1954		Oct 1, 1954		Heart Disease		Home		9:00 PM		Mary Smith, John Smith		Mary Smith		Oct 1, 1954	
John Doe		50		Male		White		Protestant		Married		Engineer		University		789 Elm St.		Nov 1, 1954		Nov 1, 1954		Cancer		Hospital		2:00 PM		John Doe, Mary Doe		John Doe		Nov 1, 1954	
Mary Doe		42		Female		Black		Muslim		Divorced		Teacher		College		101 Pine St.		Dec 1, 1954		Dec 1, 1954		Stroke		Hospital		10:00 AM		Mary Doe, John Doe		Mary Doe		Dec 1, 1954	
John Smith		58		Male																													

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VR A150
30M REV. 1-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02286

CERTIFICATE OF DEATH

02282

1. DECEASED-NAME (Type or print) Wilbur Roy Forney			2a. DATE OF DEATH Month Day Year Feb. 13 1969		2b. HOUR 3 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH May 15, 1885		6. AGE (In years last birthday) 83 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Penn.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Cecil Md.		
10. CITY OR TOWN OF DEATH Rising Sun, Md.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Calvert Manner Nursing Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Electrician	12b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Cecil	13c. CITY OR TOWN Rising Sun	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Cherry Street	
14. FATHER'S NAME First Middle Last Jacob ——— Forney		15. MOTHER'S MAIDEN NAME First Middle Last Margaret ——— Knell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 201-16-3129	17. INFORMANT Address Mrs Walter Cameron Rising Sun, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> 4369 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized arteriosclerosis</u> 3 yrs DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 3 yrs					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 6-6, 1967, to 2-13, 1969, that (I) (we) last saw the deceased alive on 2-12, 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Neil R. Taylor Jr. M.D.				DEGREE M.D.	22c. DATE SIGNED 2-14-69
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS Rising Sun, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 2-15-69	23c. NAME OF CEMETERY OR CREMATORY Brookview Cem.		23d. LOCATION (City or Town) (County) (State) Rising Sun Cecil Md.
24. FUNERAL DIRECTOR James H. Muller Jr.			ADDRESS Rising Sun, Md.		25a. REC'D BY REGISTRAR DATE FEB 17 1969
			25b. REGISTRAR'S SIGNATURE James H. Muller Jr.		

22825

CHRONIC DEFEAT

22825

quest. Indigo also considered
page 2.

Robert M. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <i>Edna</i> First <i>Hannel</i> Middle <i>Freeman</i> Last					2a. DATE OF DEATH Month <i>Feb</i> Day <i>16</i> Year <i>1969</i>		2b. HOUR <i>4:40</i> M		
3. SEX <i>Female</i>		4. RACE <i>negro</i>		5. DATE OF BIRTH <i>June 14, 1906</i>		6. AGE (In years last birthday) <i>62</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Cotesville, Pa.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>United States</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Cecil</i> Md.			
10. CITY OR TOWN OF DEATH <i>Port Deposit</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Box 118 Route 1 Port Deposit</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Port Deposit</i>		13b. COUNTY <i>Cecil</i>		13c. CITY OR TOWN <i>Port Deposit</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>Box 118 Route 1</i>	
14. FATHER'S NAME First <i>Marshall</i> Middle <i>Pernsley</i> Last			15. MOTHER'S MAIDEN NAME First <i>Sarah</i> Middle <i>Rosetta</i> Last <i>Pernsley</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>		16b. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT Address <i>Rt St Paul Freeman Port Deposit Md</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Accident</i> <i>4360</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arterio Sclerosis, Hypertension</i> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 hours</i> <i>3 yrs</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <i>Myocarditis, Ischemia</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>July 5, 1964</i> , to <i>Feb 16, 1969</i> , that (I) (we) lost the deceased alive on <i>Feb 16, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Clarence J. Benson MD</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>2/15/69</i>			
22d. PHYSICIAN'S NAME (Type) <i>CLARENCE J. BENSON</i>				22e. ADDRESS <i>Port Deposit, Md</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>2-25-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Chestnut Grove Amk Chester</i>		23d. LOCATION (City or Town) (County) (State) <i>PA</i>			
24. FUNERAL DIRECTOR ADDRESS <i>George W Tittle Bel Air Md</i>				25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
DATE <i>FEB 27 1969</i>									

MEDICAL CERTIFICATION

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RECEIVED BY DEPT.

05588

U.S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D.C.



RECEIVED BY DEPT.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) Amanda First Middle Last						2a. DATE OF DEATH Month Feb. Day 24 Year 1969			2b. HOUR 12:30 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH 9--15--1891			6. AGE (In years last birthday) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) N.C.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Cecil Md.						
10. CITY OR TOWN OF DEATH North East R.D.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) North East R. D.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Ret. Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Mo.			13b. COUNTY Cecil		13c. CITY OR TOWN N. East R.D.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER North East R.F.D.			
14. FATHER'S NAME First Middle Last William ----- Brooks				15. MOTHER'S MAIDEN NAME First Middle Last Sally ----- Baugess								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No				16b. SOCIAL SECURITY NO.		17. INFORMANT Address Dean Gambill North East, R.F.D.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure 4270 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Diabetes												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE F.B. Robinson M.D.						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Feb 26 69				
22d. PHYSICIAN'S NAME (Type) F.B. Robinson M.D.						22e. ADDRESS Oxford Pa						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 2-27-1969		23c. NAME OF CEMETERY OR CREMATORY Conowingo Baptist		23d. LOCATION (City or Town) (County) (State) Conowingo Cecil Md.						
24. FUNERAL DIRECTOR Edmond M. Mullen				ADDRESS Rising Sun Md		25a. REC'D BY REGISTRAR DATE MAK 3 1969		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				

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Albion

Feb 26 19

F. A. Robinson M.D. Oxford Pa.
F. A. Robinson M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)		First JOSEPH		Middle ALFRED GODESKY		Last		2a. DATE OF DEATH February 5 Day 1969		2b. HOUR 3:35a
3. SEX Male		4. RACE White		5. DATE OF BIRTH May 31, 1919		6. AGE (In years last birthday) 49 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) New Jersey		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Cecil				Md.
10. CITY OR TOWN OF DEATH Perry Point		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Veterans Administration		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Molder		12b. KIND OF BUSINESS OR INDUSTRY Iron Fndry				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE New Jersey		13b. COUNTY Hudson		13c. CITY OR TOWN Bayonne		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 52 Newman Avenue		
14. FATHER'S NAME First Middle Last Steven Godesky		15. MOTHER'S MAIDEN NAME First Middle Last Mary Kotarski								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) Yes		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) WWII		17. INFORMANT Address VA Hospital Records, Perry Point, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 485x IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (X) (this hospital) attended the deceased from April 11, 1968, to Feb. 5, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did not) view the body after death.										
22b. SIGNATURE S. Goldgraben		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED Feb. 5, 1969				
22d. PHYSICIAN'S NAME (Type) SEMOUR GOLDGRABEN, M.D.		22e. ADDRESS VA Hospital, Perry Point, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan. 8, 1969		23c. NAME OF CEMETERY OR CREMATORY Holy Cross		23d. LOCATION (City or Town) (County) (State) Landon North Arlington N.J.				
24. FUNERAL DIRECTOR Grant Funeral Home		ADDRESS Box 22 North East, Md.		25a. REC'D BY REGISTRAR PPB 6 1969		25b. REGISTRAR'S SIGNATURE Charles Judge				

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VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
02290						02286						
1. DECEASED-NAME (Type or print)				First <i>Marian</i>		Middle <i>T.</i>		Last <i>Godman</i>		2a. DATE OF DEATH Month <i>2</i> Day <i>24</i> Year <i>1969</i>		
3. SEX <i>Female</i>		4. RACE <i>Cau.</i>		5. DATE OF BIRTH <i>Dec. 22, 1894</i>			6. AGE (In years last birthday) <i>74</i> YRS.			2b. HOUR <i>11:00 AM</i>		
7a. BIRTHPLACE (State or foreign country) <i>Kentucky</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Cecil</i> Md.						
10. CITY OR TOWN OF DEATH <i>Carpenters Point</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>R.F.D.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>House Wife</i>			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Cecil</i>		13c. CITY OR TOWN <i>Carpenters Pt.</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>R.F.D.</i>			
14. FATHER'S NAME First <i>James</i> Middle <i>H.</i> Last <i>Tinsley</i>			15. MOTHER'S MAIDEN NAME First <i>Elizabeth</i> Middle <i>Pogue</i> Last <i>Pogue</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown <i>No</i> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT Address <i>Marshall L. Godman, Carpenters Point, Md.</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Myocarditis</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary Arteriosclerosis</i> 7130										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 yrs - 20 yrs</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <i>Aug - 1968</i> , to <i>Feb 24, 1969</i> , that (I) (we) lost saw the deceased alive on <i>Feb 24, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Clarence I. Benson</i> M.D. DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>2/25/69</i>				
22d. PHYSICIAN'S NAME (Type) <i>Clarence I. Benson M.D.</i>						22e. ADDRESS <i>Box 123 - Port Deposit, Md</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>2/27/1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Green Lawn Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Columbus Ohio</i>						
24. FUNERAL DIRECTOR <i>Lee A. Patterson & Son, Perryville, Md.</i>						25a. REC'D BY REGISTRAR DATE <i>MAR 3 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02291

CERTIFICATE OF DEATH

02287

1. DECEASED-NAME (Type or print)		First BOOKER	Middle T.	Last HARPER	2a. DATE OF DEATH Month 2 Day 19 Year 69		2b. HOUR 10:55 am
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH 11-20-19		6. AGE (In years last birthday) 49 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Dew West, S.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Cecil Md.	
10. CITY OR TOWN OF DEATH Perry Point		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Veterans Administration		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE District of Columbia		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 450A Condon Terrace, SE	
14. FATHER'S NAME First Middle Last John Boole (D)		15. MOTHER'S MAIDEN NAME First Middle Last Marie Harper					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II		16b. SOCIAL SECURITY NO. 254-42-4092		17. INFORMANT Address VA Hospital Records, Perry Point, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis acute. 4122 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular disease. DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Feb. 12, 1969, to Feb. 19, 1969, that (I) (we) last saw the deceased alive on Feb. 12, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.							
22b. SIGNATURE Irina Reus MD.		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 2-19-69			
22d. PHYSICIAN'S NAME (Type) IRINA REUS MD.		22e. ADDRESS VA Hospital, Perry Point, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 2/22/69		23c. NAME OF CEMETERY OR CREMATORY Ware Shoale SC		23d. LOCATION (City or Town) (County) (State) SC	
24. FUNERAL DIRECTOR Hall Brothers		ADDRESS 621 Fla. Ave. NW		25a. REC'D BY REGISTRAR DATE FEB 24 1969		25b. REGISTRAR'S SIGNATURE	
HALL BROTHERS FUNERAL HOME Wash D.C.							

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02292		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		02288	
Item 8 Film 409 2/10/69 kk		CERTIFICATE OF DEATH			
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH
Walter		S.		HICKMAN	Month Day Year Feb. 12, 1969
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	2b. HOUR & MIN.
Male	White	7-24-93		75 YRS.	12:50 M
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH		
Maryland	U.S.A.	Cecil		Md.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY	
Perry Point	VA Hospital		Farm & Various	Labor	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	
Maryland	Kent	Chestertown		619 W Cannt St.,	
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First Middle Last
Stephen			Hickman (D)	Mary	Jewell (D)
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.	17. INFORMANT Address		
Yes		WW I	212-12-23-36 VA Hospital Records - Perry Point, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, bilateral</u> <u>1723</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of skin of right forehead with</u> DUE TO, OR AS A CONSEQUENCE OF <u>generalized metastasis</u> (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>12-30-68</u> , 19____, to <u>2-12-69</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE	ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED	
<u>A. L. Mooney, M.D.</u>				2-12-69	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			
A. L. MOONEY, M.D.		VA Hospital - Perry Point, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial	2/15/69	Chester Cemetery		Chestertown, Maryland	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Willis Wells		WILLIS WELLS Funeral Home - Chestertown, Md.		FEB 17 1969	

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References

1993-1994

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02293		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				02289	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) First Middle Last Ollie Mae Ingram			2a. DATE OF DEATH Month Day Year 2 - 22 - 1969			2b. HOUR P. 4:05 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH Feb. Jan. 17, 1924		6. AGE (In years lost birthday) YRS. MONTHS DAYS 45	
7a. BIRTHPLACE (State or foreign country) Shouns, Tenn.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Cecil	
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Union Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Cecil		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last Clifford Willen		15. MOTHER'S MAIDEN NAME First Middle Last no information					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. 221-14-7275		17. INFORMANT Address Ralph Ingram 132 1/2 Maffitt St., Elkton, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CORONARY THROMBOSES</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days 3 days. 4 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (the hospital) attended the deceased from Feb. 13, 1969, to Feb. 22, 1969, that (I) (we) last saw the deceased alive on Feb. 22, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Rolando A. Najera, M.D.				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2/24/69	
22d. PHYSICIAN'S NAME (Type) Rolando A. Najera, M.D.				22e. ADDRESS 105 E. Main St., Elkton, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 26, 1969		23c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		23d. LOCATION (City or Town) (County) (State) Elkton Cecil Md.	
24. FUNERAL DIRECTOR PIPPIN FUNERAL HOME				ADDRESS Elkton, Md.		25. REGISTERED BY REGISTRAR FEB 27 1969	
				DATE		25b. REGISTRAR'S SIGNATURE [Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1/59

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) Adeline Reba McCall			First Middle Last			2a. DATE OF DEATH Month Day Year Feb. 22 1969			2b. HOUR 5:35 A. M.
3. SEX Female		4. RACE White		5. DATE OF BIRTH Oct. 12, 1889			6. AGE (In years lost birthday) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Cecil			
10. CITY OR TOWN OF DEATH North East		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) R.D. # 2			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Cecil		13c. CITY OR TOWN Charlestown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last Lewis A. McCall				15. MOTHER'S MAIDEN NAME First Middle Last Carrie Clark					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No (yes, no, or unknown)		16b. SOCIAL SECURITY NO. 215-56-1241		17. INFORMANT Nellie V. McCall			Address Charlestown, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Vascular Failure 4122 DUE TO, OR AS A CONSEQUENCE OF (b) C.V.A. - Cerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension- H.C.V.D.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min. 4 wks. years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) G.A.S.C. - A.S.C.V.D., Fractured Hip, Large Bed Sores.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Jan. 8, 1969 , to Feb. 22, 1969 , that (I) (we) last saw the deceased alive on Feb. 21, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Luis M. Cuza</i>				DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Feb. 24, 1969	
22d. PHYSICIAN'S NAME (Type) Luis M. Cuza M.D.				22e. ADDRESS 322 E. Cecil Ave. North East, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2-26-69		23c. NAME OF CEMETERY OR CREMATORY North East Methodist			23d. LOCATION (City or Town) (County) (State) North East Cecil Md.		
24. FUNERAL DIRECTOR <i>Grant Funeral Home</i>				ADDRESS Box 22 North East, Md.		25a. REC'D BY REGISTRAR FEB 26 1969		25b. REGISTRAR'S SIGNATURE <i>Charles J. [unclear]</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

02295										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										02291																			
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																			
First Middle Last Arthur D. Moon										Feb Month 8 Day 1969 Year										6 P M																			
3. SEX Male					4. RACE White					5. DATE OF BIRTH Mar. 10, 1923					6. AGE (In years last birthday) 45 YRS.					IF UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS. HOURS MIN.														
7a. BIRTHPLACE (State or foreign country) Md.					7b. CITIZEN OF WHAT COUNTRY? U.S.A.					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH Cecil Md.																								
10. CITY OR TOWN OF DEATH Elkton					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Union Hospital					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Engineer					12b. KIND OF BUSINESS OR INDUSTRY Railroad																								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.					13b. COUNTY Cecil					13c. CITY OR TOWN North East					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER 108 E. Cecil Ave.																			
14. FATHER'S NAME First Middle Last John H. Moon					15. MOTHER'S MAIDEN NAME First Middle Last Clara A. Loke																																		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No					16b. SOCIAL SECURITY NO. 716-12-3092					17. INFORMANT Address Elizabeth B. McMullen Charlestown, Md.																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 5 yrs.																								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																							
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)					21f. LOCATION Street or R.F.D. No. City or Town County State																													
22a. I certify that (I) (this hospital) attended the deceased from 7-8, 1963, to 2-8, 1969, that (I) (we) lost saw the deceased alive on 2-8, 1969, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																							
22b. SIGNATURE Jay S. Barnhart Jr.															DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED 2-10-69														
22d. PHYSICIAN'S NAME (Type) Jay S. Barnhart Jr.															22e. ADDRESS 4 Mauldin Ave North East, Md.																								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE 2-12-69					23c. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery					23d. LOCATION (City or Town) (County) (State) Wilmington, New Castle Del.																								
24. FUNERAL DIRECTOR Grant Funeral Home															ADDRESS North East, Md.										25a. REC'D BY REGISTRAR DATE FEB 13 1969					25b. REGISTRAR'S SIGNATURE Charles Judge									

MEDICAL CERTIFICATION

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FMS-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 28 Film 409 2-18-MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) HARRY SHELTON OSBORNE			20. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 2 11 19 69 5:35 PM		2b. HOUR
3. SEX Male	4. RACE White	5. DATE OF BIRTH Jan. 27, 1914	6. AGE (In years last birthday) 55 YRS.	IF UNDER 1 YEAR MONTHS OAYS	IF UNDER 24 HRS. HOURS MIN.
70. BIRTHPLACE (State or foreign country) Tennessee		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Union Hospital		120. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Carpenter	
130. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Cecil		13c. CITY OR TOWN Elkton	
14. FATHER'S NAME Henson		15. MOTHER'S MAIDEN NAME Inez Shupe		13e. STREET AND NUMBER R. D. 4, Andora	
160. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 232-18-1745		17. INFORMANT Mrs. Ella Mae Osborne, Elkton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 303.9 Watty liver Acute alcoholism DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)					
190. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
210. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. _____ P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Edward F. Wilson		M.D. Edward F. Wilson, M.D.		22b. DATE SIGNED 2/12/69	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ADDRESS (Street, city, town, or county)	
230. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2/15/69		23c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Memorial Park, Elkton, Md.	
24. FUNERAL DIRECTOR Alfred E. Hicks		ADDRESS Hicks Home for Funerals, Elkton, Md.		250. REGISTRAR FEB 18 1969	
				25b. REGISTRAR'S SIGNATURE [Signature]	

02222

WESTERN LABORATORY CERTIFICATE OF DEATH

02222

STATE OF TEXAS
COUNTY OF DALLAS

Name of Deceased		Sex		Age		Date of Death		Place of Death	
John Doe		Male		45		10/15/1950		Dallas, Texas	
Cause of Death		Manner of Death		Occupation		Education		Marital Status	
Heart Disease		Natural		Teacher		High School		Married	
Medical History		Previous Illnesses		Family History		Social History		Hobbies	
Hypertension		None		None		None		None	
Medication		Treatment		Autopsy		Burial		Remarks	
Aspirin		None		None		None		None	
Signature of Physician		Signature of Coroner		Signature of Registrar		Signature of Witness		Signature of Deceased	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Certificate		Time of Certificate		Place of Certificate		County of Certificate		State of Certificate	
10/15/1950		10:00 AM		Dallas, Texas		Dallas		Texas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH Month Day Year			2b. HOUR M
Arthur			S.		REISHER		February 7, 1969					
3. SEX Male			4. RACE White			5. DATE OF BIRTH 5-31-96			6. AGE (In years lost birthday) 72 YRS.			IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) Penna.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH Cecil			IF UNDER 24 HRS HOURS MIN.
10. CITY OR TOWN OF DEATH Perry Point			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VA Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Shoemaker			12b. KIND OF BUSINESS OR INDUSTRY Shoemaking			Md.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. CITY OR TOWN Washington			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 719 George St.,			
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) Yes			16b. SOCIAL SECURITY NO. WW I 214-09-57-81			17. INFORMANT VA Hospital Records - Perry Point, Maryland			Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, bilateral</u> <u>4339</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>C. V. A. (Cerebral infarction)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral arteriosclerosis</u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (1) (this hospital) attended the deceased from <u>5-3-61</u> , 19 <u> </u> , to <u>2-7-69</u> , 19 <u> </u> , that (1) (we) last saw the deceased alive on <u>2-7-69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>A. L. Mooney, M.D.</u>						DEGREE ATTENDING <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED 2-7-69			
22d. PHYSICIAN'S NAME (Type) A. L. MOONEY, M.D.						22e. ADDRESS VA Hospital - Perry Point, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 2/10/69			23c. NAME OF CEMETERY OR CREMATORY Cedar Grove Cemetery			23d. LOCATION (City or Town) (County) (State) Chambersburg, Pe nna			
24. FUNERAL DIRECTOR <u>Lee A. Patterson & Son</u>						ADDRESS Perryville, Md.			25a. REC'D BY REGISTRAR DATE FEB 14 1969		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
John L. Ryan						Month Day Year Feb 9 1969			M
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
Male		Cau		March 15, 1898			70 YRS.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Delaware		U.S.A.				Cecil Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Elkton			Union Hospital			Retired			Carpenter
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Cecil		Charlestown				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last Frank B. Ryan			First Middle Last Kate B. Jackson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No			218-03-9833		J. O. Ryan, Perryville, Maryland.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Vascular Failure</u>									30 minutes
1621 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <u>Mediastinal & Lung Metastasis</u>									1 year
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Bronchogenic Carcinoma</u>									2 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<u>osteo Arthritis - deformant</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>9-24, 1954</u> to <u>2-9, 1969</u> , that (I) (we) last saw the deceased alive on <u>2-8-1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Luis M. Cuza MD</u> DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>2-11-69</u>		
22d. PHYSICIAN'S NAME (Type) <u>LUIS M. CUZA, MD.</u>					22e. ADDRESS <u>322E. Cecil Ave. North East, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
<u>Burial</u>		<u>2/11/1969</u>		<u>North East Cemetery</u>		<u>North East Cecil Md.</u>			
24. FUNERAL DIRECTOR <u>Lee A. Patterson & Son</u> ADDRESS					25a. REC'D BY REGISTRAR <u>FEB 14 1969</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

2250

1. $\frac{1}{2} \times \frac{1}{2} = \frac{1}{4}$ (1/4 of the area is shaded)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
45M - 1/69

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
02299 CERTIFICATE OF DEATH 02295									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Joseph			GIRFORD SCARBOROUGH			February 20, 1969			4:48 P
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		White		7-5-11		57 YRS.		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Cecil Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Perry Point			VA Hospital			Lawyer			Law
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Cecil		Elkton			200 Kentmere Ave.,	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
J. William Scarborough			Nelly Kerr						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
Yes WW II			213-12-54-34		VA Hospital Records - Perry Point, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u>									Sudden
4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Occlusion, severe</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Heart Disease with severe sclerosis of Coronary Arteries</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
<u>Diabetes Mellitus</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>7-10-68</u> , 19 <u>68</u> , to <u>2-20-69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					22c. DATE SIGNED				
A.L. Mooney, M.D.					Feb. 20, 1969				
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
A. L. MOONEY, M.D.					VA Hospital - Perry Point, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		2/24/69		FRIENDS CEMETERY		CALVERT CECIL Md			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Pippin Funeral Home,					Elkton, Md.		FEB 24 1969		

02500

02500

UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

WATER RESOURCES DIVISION
SALT LAKE CITY, UTAH

TO: SAC, SALT LAKE CITY
FROM: SAC, DENVER

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

BY: [Illegible]

FOR: [Illegible]

THROUGH: [Illegible]

BY: [Illegible]

FOR: [Illegible]

THROUGH: [Illegible]

BY: [Illegible]

FOR: [Illegible]

THROUGH: [Illegible]

BY: [Illegible]

FOR: [Illegible]

THROUGH: [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove to carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1-7-65

02300										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										02296														
1. DECEASED-NAME (Type or print) First Middle Last										2a. DATE OF DEATH Month Day Year										2b. HOUR														
Merle W. Simperts										Feb. 21 1969										4:00 AM														
3. SEX male					4. RACE White					5. DATE OF BIRTH 6/7/05					6. AGE (In years last birthday) 63-64 YRS.					IF UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) Maryland					7b. CITIZEN OF WHAT COUNTRY? USA					B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH Cecil County Md.																			
10. CITY OR TOWN OF DEATH Elkton					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Union Hospital					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Mail Clerk					12b. KIND OF BUSINESS OR INDUSTRY Civil Service																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland					13b. COUNTY Cecil					13c. CITY OR TOWN North East					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER 407 S. Maryland Ave.														
14. FATHER'S NAME First Middle Last Harry Simperts					15. MOTHER'S MAIDEN NAME First Middle Last Mary Devore					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO (If yes give war or dates of service)										16b. SOCIAL SECURITY NO. 188-05-1346					17. INFORMANT Mrs. Bess F. Simperts Address 407 S. Md. Ave. North East, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC ADENOCARCINOMA OF COLON</u> <u>1538</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>11 YEARS</u>																																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)																																		
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																								
22a. I certify that (I) (this hospital) attended the deceased from <u>8 OCT</u> , 19 <u>68</u> , to <u>present</u> , 19 <u>69</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>20 Feb</u> , 19 <u>69</u> , and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above, (I) (<u>we</u>) (<u>did</u>) (<u>did not</u>) view the body after death.																																		
22b. SIGNATURE <u>Robert L. Gray</u> MD DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>															22c. DATE SIGNED <u>21 Feb 1969</u>																			
22d. PHYSICIAN'S NAME (Type) Robert L. Gray															22e. ADDRESS 123 W. High St. Elkton, Md.																			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE <u>2-25-29</u>					23c. NAME OF CEMETERY OR CREMATORY St. Mary Anne's					23d. LOCATION (City or Town) (County) (State) North East Cecil Md.																			
24. FUNERAL DIRECTOR <u>Grant Funeral Home</u> ADDRESS <u>Box 22 North East, Md.</u>															25a. REC'D BY REGISTRAR <u>EEA 25 1969</u>					25b. REGISTRAR'S SIGNATURE <u>William J. Jones</u>														

02328

STATE OF OHIO

1901

CHAS. A. BROWN

CHAS. A. BROWN

CHAS. A. BROWN

CHAS. A. BROWN

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VR A15 (4)
30M REV. 1/68

02301												MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH												02297			
1. DECEASED-NAME (Type or print)						First		Middle		Last		2a. DATE OF DEATH						2b. HOUR									
Lily						B.		Slade		February 10, 1969						M											
3. SEX				4. RACE				5. DATE OF BIRTH				6. AGE (In years last birthday)				IF UNDER 1 YEAR		IF UNDER 24 HRS.									
Female				White				May 12, 1893				75 YRS.				MONTHS		DAYS									
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH				12b. KIND OF BUSINESS OR INDUSTRY											
England				U.S.A.								Cecil				Md.											
10. CITY OR TOWN OF DEATH						11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)						12b. KIND OF BUSINESS OR INDUSTRY									
Elkton						Union Hospital						Housewife						--									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE						13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER															
Maryland						Cecil		Elkton				Box 218, R.D. # 3															
14. FATHER'S NAME						First		Middle		Last		15. MOTHER'S MAIDEN NAME						First		Middle		Last					
Absclom								Joyce				Louisa						Jane		Beaton							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)						16b. SOCIAL SECURITY NO.						17. INFORMANT						R.D.# Address									
No												Leonard F. Slade, Elkton, Md.						21921									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 1. DEATH WAS CAUSED BY:																											
IMMEDIATE CAUSE (a) ACUTE ANTERIOR MYOCARDIAL INFARCTION																											
4109 DUE TO, OR AS A CONSEQUENCE OF																											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																											
(b) ASCVD																											
DUE TO, OR AS A CONSEQUENCE OF																											
(c)																											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																											
Diabetes mellitus																											
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)						21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)															
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>						21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)						21f. LOCATION Street or R.F.D. No. City or Town County State															
22a. I certify that (I) (this hospital) attended the deceased from 1967, to present, 1969, that (I) (we) last saw the deceased alive on 10 Feb 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.																											
22b. SIGNATURE Robert L. Gray M.D. DEGREE																		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 14 Feb 1967					
22d. PHYSICIAN'S NAME (Type) Robert L. Gray																		22e. ADDRESS 123 W. High St. Elkton, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)						23b. DATE						23c. NAME OF CEMETERY OR CREMATORY						23d. LOCATION (City or Town) (County) (State)									
Burial						2/14/69						Gracelawn Memorial Park, Wilmington, Del.															
24. FUNERAL DIRECTOR Ralph E. Hicks ADDRESS																		25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Hicks Home for Funerals, Elkton, Md.																		DATE FEB 18 1969									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301-W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR 10:10	
JOHN			Wesley SMITH			Month 2 Day 27 Year 69			
3. SEX Male		4. RACE White		5. DATE OF BIRTH 10-16-07		6. AGE (In years last birthday) 61 YRS.		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Cecil		12b. KIND OF BUSINESS OR INDUSTRY auto	
10. CITY OR TOWN OF DEATH Perry Point		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Veterans Administration		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Mechanic					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. CITY OR TOWN Harford		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 503 Kennard Avenue			
14. FATHER'S NAME First Middle Last John Henry Smith (D)			15. MOTHER'S MAIDEN NAME First Middle Last Alice Dyer (D)						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) Yes		16b. SOCIAL SECURITY NO. WW II 226-72-2409		17. INFORMANT Address VA Hospital Records, Perry Point, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, bilateral</u> <u>492X</u> DUE TO, OR AS A CONSEQUENCE OF <u>Pulmonary emphysema with right</u> Conditions, if any, which gave <u>side heart failure (Cor pulmonale).</u> rise to immediate cause (a), <u>side heart failure (Cor pulmonale).</u> stating the underlying cause <u>side heart failure (Cor pulmonale).</u> lost. (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb. 21</u> , 19 <u>69</u> , to <u>Feb. 27</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>A. L. Mooney M.D.</u> DEGREE ATTENDING <input type="checkbox"/> MED. <input type="checkbox"/> STAFF <input checked="" type="checkbox"/> PHYS. DIRECTOR PHYS.						22c. DATE SIGNED <u>2-27-69</u>			
22d. PHYSICIAN'S NAME (Type) <u>A. L. Mooney, M.D.</u>						22e. ADDRESS <u>VA Hospital, Perry Point, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>3-3-69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md.</u>			
24. FUNERAL DIRECTOR <u>McCOMAS Funeral Home Abington, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 3 1969</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH MATED			2b. HOUR
Theresa E. Starliper						Feb. 8 1969			M
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD	2d. HOUR
Female	White	Mar. 1, 1902	66 YRS.					Feb. 8 1969	2:20 P.M.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.
Penna.		USA				Cecil			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Elkton			Union Hospital			Housewife			Home
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Penna.			Delaware		Morton			409 Highland Ave.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			ADDRESS			
First Middle Last			First Middle Last						
John Eberwine			Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, state or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS
No			204-07-6408			William D. Starliper			Morton, Penna.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY THROMBOSES DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROTIC CARDIOVASCULAR DIS. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20-30 min. ? years.
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED			
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			Feb. 8, 1969			
Rolando A. Najera, M.D.			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			Feb. 12, 1969		St. Peter & Paul		Springfield Delaware Penna.		
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Grant Funeral Home					FEB 11 1969				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02304

CERTIFICATE OF DEATH

02300

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CECIL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RISING SUN		c. LENGTH OF STAY IN Hs 10 YRS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RISING SUN (RURAL)		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WINIFRED PUGH STUART		4. DATE OF DEATH Month FEB. Day 13 Year 1969	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 15, 1893
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (County & State, or foreign country) VERGINIA		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME WILLIAM R. PUGH		14. MOTHER'S MAIDEN NAME ELEANOR MOORE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-10-3139	
17. INFORMANT MRS JAMES LAWSON JR.		Address RISING SUN, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Arteriosclerotic heart disease CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST. (b) 5 yrs. (c)			INTERVAL BETWEEN ONSET AND DEATH 5 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6-1 , 19 67 , to 2-13 , 19 69 , that (I) (we) last saw the deceased alive on 2-12 , 19 69 , and that death occurred at 9A M, from causes and on the date stated above.			
22a. SIGNATURE Neil R Taylor Jr		22b. DATE SIGNED 2-13-69	
22c. PHYSICIAN'S NAME (Type) Neil R Taylor Jr		22d. ADDRESS M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF FEB. 16, 1969	23c. NAME OF CEMETERY OR CREMATORY BROOKVIEW	23d. LOCATION (City or Town) (County) (State) RISING SUN, CECIL, MD
24. FUNERAL DIRECTOR RALPH M. REED		25a. REC'D BY REGISTRAR FEB 17 1969	
ADDRESS RISING SUN, MD.		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR				
Josephine E. Wardell						Month Day Year			4:48 PM				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Female		White		Oct. 12, 1892			78 YRS.		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.	
Delaware			USA						Cecil				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Elkton			Union Hospital			Housewife			Home				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER	
Maryland			Cecil			North East			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			215 S. Main St.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last										
Harry C. Milbourne			Sophia Payne										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown <input type="checkbox"/>			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address				
No						Harry T. Milbourne			4200 Verona Dr. Wilmington 8, Del.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) METASTATIC ADENOCARCINOMA STOMACH													
174X DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
(b) DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 1963, to present, 19, that (I) (we) last saw the deceased alive on Feb 7, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.													
22b. SIGNATURE Robert L. Gray M.D. DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 10 Feb 1969.				
22d. PHYSICIAN'S NAME (Type) Robert L. Gray						22e. ADDRESS 123 W. High St. Elkton, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Feb. 11, 1969			23c. NAME OF CEMETERY OR CREMATORY St. Barnabas			23d. LOCATION (City or Town) (County) (State) Marshallton New Castle Del.				
24. FUNERAL DIRECTOR Grant Funeral Home Paul R. Rouch						ADDRESS Box 22 North East, Md.			25a. REC'D BY REGISTRAR DATE FEB 13 1969				
									25b. REGISTRAR'S SIGNATURE J. Charles Judge				

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• J. L. •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02302

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Warwick				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Warwick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Emma Middle P. Last Williams				4. DATE OF DEATH Month Feb Day 1 Year 1969			
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar 4, 1891		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Pope				14. MOTHER'S MAIDEN NAME Rose Hoover			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Walter Williams - Warwick, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Embolism 4100 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Artery Disease DUE TO (c) Chronic Hypertention						INTERVAL BETWEEN ONSET AND DEATH 1 day 2 years 11 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 15, 1957 to Feb. 1, 1969 , that I last saw the deceased alive on Feb. 1, 1969 , and that death occurred at 3:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Warwick - Md. DATE SIGNED 2-4-69							
ACTUAL SIGNATURE Allan R. Cruchley M.D.				PHYSICIAN'S NAME (Type) Allan R. Cruchley, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Feb 5/1969		22c. NAME OF CEMETERY OR CREMATORY Old Bohemia Cem.		22d. LOCATION (City, town, or county) (State) Warwick - Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Lester Davis ADDRESS Middletown, Del.				24a. REC'D BY REGISTRAR FEB 7 1969		24b. REGISTRAR'S SIGNATURE Charles Judge	

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